

MICHAEL CLOUD
27TH DISTRICT, TEXAS

COMMITTEE ON
OVERSIGHT AND REFORM

RANKING MEMBER,
ECONOMIC AND CONSUMER POLICY
SUBCOMMITTEE

SCIENCE, SPACE &
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CLOUD.HOUSE.GOV

Privacy Release Form

Full Name (First, Middle, Last): _____

Permanent Address: _____

City: _____ State: Texas Zip Code: _____

Home Phone: _____ Cell phone: _____

Date of Birth: _____ Social Security Number: _____

E-Mail: _____

I authorize the agencies indicated below to release information regarding my file to the Office of Congressman Michael Cloud. Please only select those which apply to your concern.

Dept. of Agriculture	Dept. of HUD	Dept. of Veterans Affairs
Dept. of Commerce	Dept. of Interior	National Archives / Records
Dept. of Defense	Dept. of Justice	Office of Personnel Mgmt.
Dept. of Education	Dept. of Labor	Social Security Admin.
Dept. of Energy	Dept. of State	U.S. Postal Service
Dept. of Health & Human Svcs.	Dept. of Transportation	Other: _____
Dept. of Homeland Security	Dept. of Treasury	

By signing below, I allow the Office of Congressman Michael Cloud to contact the appropriate agencies, forward my correspondence, discuss the matter, and receive pertinent information from federal agencies. It is my understanding that this form is being used in compliance with the Privacy Act of 1974.

Constituent Signature

Date

Constituent Liaison (Staff Signature)

Date

Please complete back side of page as well.

Below, please briefly describe the nature of your concern/request and the steps you have already taken to rectify the matter. Also, describe what you would like for our office to do regarding the situation:

I ☐ DO ☐ DO NOT authorize the office of Congressman Michael Cloud to release information about my case to Third-Party individuals. *If you indicated "DO", you may list up to 2 authorized contacts (ex. Legal Representative, Spouse, Sibling, Child, and Close Friend) below. We will only share information with those listed below if they contact our office. There will be no outgoing contact, under any circumstances, from our staff to Third-Party individuals. At any time, you may provide written notice asking that individuals be removed as authorized contacts on your case.*

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I certify, under perjury, that 1) I provided or authorized all the information in this privacy release and any document submitted with it; 2) I reviewed and understand all the information contained in my privacy release and submitted with it; and 3) all this information is complete, true, and correct.

Constituent Signature

Date

Constituent Liaison (Staff Signature)

Date

*Please note, our office is limited to addressing issues with Federal Agencies only. State and Local issues will be forwarded to corresponding offices.